

## New horizons in frailty: The contingent, the existential and the clinical

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### Abstract

The increasing operationalisation of frailty including in primary care brings with it a risk of oversimplifying diagnostic processes and inadvertently barring access to comprehensive geriatric assessment services. The emphasis on measurement tools, despite updated guidance to the contrary, can also undermine the importance of clinical judgement, meaning that non-contractual evidence-based opportunities for medical optimisation (e.g. exercise promotion, nutrition optimisation) as well as appropriate access to social supports may be missed.

Another significant consequence is to open up an ever-widening gap between clinical approaches and lived experience, including overlooking strengths and resources in problem-based approach and inadvertently alienating the very group it is trying to assist.

This article argues that the next horizon in frailty should not be to continue to refine its operationalisations but rather to reconnect with more holistic approaches to health and illness in old age, which are more in tune with the tradition of geriatric medicine. Building on recent trends to shift conceptualisation of health and illness in old age, this project would benefit from sociological and humanities-based approaches that foreground older people's lived experience using theoretically informed description focused on a first-person perspective. In reconfiguring what we think frailty is, such a shift will bring us closer to the views and experience of older people who live with frailty. We see a brighter horizon for frailty in that direction.

## Introduction

In the clinical literature, for the past decade frailty has been dominated by two approaches: the phenotype model, proposed by Linda Fried and colleagues, and the Frailty Index proposed by Kenneth Rockwood's group, with a vast and multiplying literature devoted to applying and reaffirming one or other of those two positions. Both of these are centred on signs and symptoms of the individual body. Following the 2017 GMS contract, all primary care practices have been incentivised to identify older patients with moderate or severe frailty, extending the use of these and similar 'appropriate' tools into primary care. One of the unintended consequences of the dominance of the operationalisation of frailty in either of these forms include clinical assumptions that frailty is a diagnosis, rather than a syndrome or state caused by other factors, which brings the danger of oversimplifying diagnostic processes and inadvertently barring access to comprehensive geriatric assessment services. The emphasis on measurement tools, despite updated guidance to the contrary [1], can also undermine the importance of clinical judgement, meaning that non-contractual evidence-based opportunities for medical optimisation (e.g. exercise promotion, nutrition optimisation) as well as appropriate access to social supports may be missed. Another significant consequence is to open up an ever-widening gap between clinical approaches and lived experience and inadvertently alienate the very group it is trying to assist.

In this article we argue that the next horizon in frailty should not be to continue to refine its operationalisations and have them compete for their rapid implementation into clinical practice, but rather to take a step back, look critically for unintended consequences, and reconnect with more holistic approaches to health and illness in old age, which are more in tune with the tradition of geriatric medicine. As well as building on recent trends [2] to shift

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conceptualisation of health and illness in old age, in so doing it would benefit from sociological and humanities-based approaches that foreground older people’s lived experience using theoretically informed description focused on a first-person perspective. In reconfiguring what we think frailty is such a shift will also bring us closer to the views and experience of older people who live with frailty. We see a brighter horizon for frailty in that direction.

**The disjunction between clinical approaches and lived experience**

There is an emerging body of research, coming from the social sciences, humanities, social work and nursing and focused on empirical work with older people themselves, that is highly critical of clinical representations of frailty. This critique focuses, inter alia, on its failure to take into account the role played in precipitating frailty by domains outside the biological, including social disadvantage [3]; its overlooking of positive aspects of frail embodiment/resilience [4]; its incorporation of psycho-social aspects in a dualistic framework that posits the separation of mind and body [5]; its perpetuation of decline narratives; and ultimately its potentially (albeit unintentionally) harmful impact on older people who are labelled ‘frail’, which may in turn trigger frailty identity crises [6] precipitating a ‘cycle of decline’ [7]. The importance of subjectivity is also highlighted in clinical literature: for example, negative representations of ageing may underpin a decline in objective walking speed [8]; in addition, the English Longitudinal Study of Ageing suggested that older people who have a more positive attitude to ageing may be at reduced risk of becoming physically frail or pre-frail [9].

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3 In the wider social domain, the influence of frailty discourses on reconfiguring old age have  
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5 been significant, separating the ‘third’ age (productive, healthy, associated with ‘successful’  
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7 ageing) from the fourth age (devalued, decrepit, senescent, ‘geriatric’), into which latter  
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9 category a frailty label may serve as a key gateway. The fourth age as a social imaginary [10]  
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12 undermines any concept that old age may contain value and meaning. It stresses separation  
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14 rather than continuity both from other (more ‘successfully’ ageing) older people and from  
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16 experiences of vulnerability common through the life course including those precipitated by  
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18 structural conditions configuring socio-economic insecurity and increased social inequality  
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20 that undermine well-being and increase poor health as summed up in the term ‘precarity’  
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22 [11]. For all these reasons, older people themselves fear and resist the label, thus potentially  
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24 alienating them from practitioners and ‘frailty’ services. This has resulted in calls in some  
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26 quarters for the term to be dropped altogether [12] or for its use to be limited *because* of its  
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28 significant limitations, calling instead for a broader strengths-based approach to older  
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30 people’s health and illness, ‘defined by what they can, as much as what they cannot, do’ [13]  
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32 and thinking “diversabilities” rather than just “disabilities”.

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41 However, a similar understanding is emerging in medicine. This is reflected in the emerging  
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43 concept of “intrinsic capacity”. Defined in the World Health Organisation’s (WHO) World  
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45 Report on Ageing and Health [14] as the combination of physical and cognitive attributes of  
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47 an individual, its interplay with the individual’s social environment shapes the functional  
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49 ability that the WHO posits as the definition of healthy ageing [2]. This concept moves away  
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51 from a disease-centred approach to one that emphasizes the positive attributes that ordinarily  
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53 support ‘health’ in the sense of being able to be and do what one values [15]. Professional  
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55 assessment within this framework would require a longitudinal observational approach rather  
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57 than a single ‘snapshot’ assessment; intervention can then move from a preventive or reactive  
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focus to an emphasis on supporting the everyday capacity of the individual. This conceptual apparatus has been hailed as a potentially revolutionary transformation to viewing health and illness in old age [2]; as such it is well-placed to capture the complexity of frailty, both as a clinical state and as a lived experience, as well as to support interventions aimed at restoring functionality.

**The expertise of geriatric medicine: clinical and social**

Whilst agreeing with the rationale behind the critiques of frailty as it is currently operationalised – particularly the disjunction between clinical approaches and lived experience that has emerged- we are not advocating that the term be dropped. Clearly frailty exists and signifies something ‘real’. Nor do we think clinical ‘frailty’ is necessarily and inherently too limited to be able to encompass lived experience, even though since its operationalisation over the past two decades it has been almost entirely focused on physiological or functional limitations. Indeed, our view is that frailty is broader than clinical symptoms and encompasses more than a medical syndrome alone and that geriatric medicine has the particular knowledge-base to overcome this disjunction. Historically, geriatric medicine has roots in the understanding that social and medical problems are inextricably intertwined in the lives of older patients and indeed that this linkage forms part of the unique nature of health and illness in old age, recognition of which is part of the unique expertise of geriatrics. As found in the works of pioneering geriatricians such as Amulree, Sheldon, Brocklehurst and others, going all the way back to Marjory Warren, the discipline was established to take a holistic approach, remedy as much as possible and focus on restoring function in such a way as to enable patients to return to their own homes and their lives [16]. Revisiting this may inspire the reintegration of not just the social and medical, as advocated

by the WHO's approach to healthy ageing, but also of a rapprochement between clinical knowledge and lay experience of frailty.

There is recognition of the importance of a more holistic approach within the field of frailty itself, especially through CGA [17]. Firstly, running alongside the trend to operationalise frailty in terms of individual and largely physiological deficits is the agreement that frailty is a state of pre-existing vulnerability which, combined with a stressor of some kind (either illness or an external crisis or both), can have significant negative consequences [18, 19]. Campbell and Buchner point out: 'the interaction of the individual with the environment is central to this concept of frailty' [18]. Although the kinds of stressors discussed usually relate to health – a minor illness or infection, starting new medication and so on [19] - this conceptual framework is elastic enough theoretically to encompass events in the social world that are contingent (such as falls, illness and other risks arising from systemic and structural conditions) or existential (dilemmas that affect everyone as well as those that are specific to old age, such as bereavement, grief, loneliness, loss of meaning or value) [20]. The connection between social events and health is corroborated in neuroendocrinology [21] and potentially traceable through biomarkers [12] conceptualised through the allostatic load [23]. This framework can also take into account the strengths and resources that co-exist and which may require additional support at this time.

Secondly, rather than seeing 'frail elderly people as complex systems on the brink of failure' [24] there is increasing recognition that frailty is dynamic, involving improvement as well as continued decline [25] and that over time, indeed, the 'usual' pattern of frailty involves older people moving between pre-frail, robust and frail positions [25]. Thus the 'brink' may in

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many instances be one of renewed or improved health. Given that prefrail older people are far more likely to move to the robust position than are those already classified as frail (approximately 25 per cent compared to 3 per cent respectively) [25], this suggests the importance of interventions that are both sensitive and timely. However, currently in primary care the obligation on GPs, following routine identification, is to intervene only in cases of severe frailty, thus missing an opportunity to delay or reverse frailty earlier in its trajectory [1]. Moreover, there is no consistent approach to the kinds of interventions that GPs should utilise. A recent review of the evidence [26] suggest that a combination of strength exercises and protein supplementation is best for a combination of ease and effectiveness in improving frailty and suggests that a toolkit should be made available to GPs summarising the most effective interventions. Missing from this mooted toolkit, however, is any reference to social support dimensions.

**Bridging the gap**

Sociological studies comprising interviews and thick observational data report that older people talk about adapting to and indeed thriving in the ‘ordinary’ conditions of ageing, involving ‘diminished everyday competence’ [27] which comprises a range of ‘problems’ all the way from weaker sight and hearing to stiff joints and frailty. Part of the experience of adaptation is the learning of new skills, ways of coping with reduced strength and the challenges of the environment. Disruption of this everyday competence, for example through the occurrence of contingent or existential events is what leads to felt frailty. A mixture of appropriate interventions at this point can support the older person to return to a pre-frail or robust state rather than fluctuate into further frailty. The experience of older people strongly suggests that, although frailty is a severe diminishment of everyday competence, it is still part

of that continuum, can be reversed or delayed, and is not, therefore, something separate. This is what is recognised in the clinical arena in claims that the aim of frailty interventions is to stabilise frailty and reduce the more general vulnerability it signals [19] (rather than, for example, ‘combat’ frailty). Earlier versions of the frailty index directly reference John Brocklehurst’s ‘balance beam model’ which incorporates social and relational factors into its understanding of frailty as a dynamic state [28]. The task then for geriatricians is to go from acknowledging this in the abstract, viewing biology and the social as important but separate in the ‘frailty syndrome’, or seeing its existence as lying beyond the domain of medicine, to an appreciation of this ‘damage’ as something that involves not just cells, tissues and organs (where it might have been present for a considerable length of time) but the lived self. The clinical gaze intuitively grasps these principles, in the ‘know it when I see it’ approach but this ‘art’ of medicine is in danger of being subsumed in the increasingly technical approaches that characterise approaches to frailty detection and management, especially in busy settings.

### **The contribution of approaches from social sciences and the humanities to bridging the gap**

In this aim, medicine can learn from sociological approaches to the lived experience of health and illness. A well-established interpretive tradition critiques the reductionist nature of biomedical readings of the body and disease, and stresses the importance of embodied, biographical and social factors in the illness experience. Narrative-based methods can aid the geriatrician in understanding how illness is experienced as a biographical event related to meaning and identity [29, 30]. Phenomenological methods, influenced by the work of Merleau-Ponty, can aid the geriatrician to understand health and illness from the perspective not of medicine but of the older person [31]. It contrasts the objective anatomical body



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(Körper) with that of the lived body (Leib), the biological body with the existential body, and stresses the importance of the latter in understanding how a person experiences illness, including in its fluctuations [32]. Phenomenology aims at ‘direct description of our experience as it is’[33], although more sociologically informed accounts look not so much for ‘essential’ structures of experience, as sought by philosophers, but are more sensitised to the way experiences are structured through social forces, which can in turn increase vulnerability, highlighting the role of age, gender, class and so on in shaping and mediating the trajectories of frailty. Interpretive concepts and methods can explain how, for example, the ‘normality’ of long-term conditions and other illness may be experienced more in the oldest patients than in the young-old for whom sudden illness/impairment may feel like a biographical ‘rupture’, with adverse consequences for coping and well-being [34, 35]. Both experience and onset of frailty have been shown to be strongly dependent on life history, with accumulated disadvantages leading to an earlier experience of frailty and poorer outcomes [36]. Interpretive methods can tease out if and how, under such circumstances, the social context in which frailty arises might be more impactful on the subsequent frailty trajectory than the health crisis which precipitated it. Similarly, it is known that gender is a factor in the experience of frailty in that whilst more women than men are frail, they are also more likely to fluctuate between health and frailty, although frailty is less of a ‘risk’ for them, at all stages, than men in a paradox that is currently not well understood [2]. Exploring lived experience through an interpretive lens may shed light on this paradox and help tailor interventions accordingly. For example, different interventions are appropriate for contingent and existential frailty factors respectively. The former are potentially modifiable by multidisciplinary interventions to address the risk of falls, poor nutrition, ensure aids and adaptations; what is needed for the latter, by contrast, is social, relational and spiritual support [37]. These are promising new horizons for frailty.

A phenomenological toolkit for use by both patients/carers and clinicians to increase mutual understanding and communication was developed by the philosopher Havi Carel [38]. It includes three elements: (i) shifting the focus away from the disease entity toward the experience of illness; (ii) highlighting the contrasting perspectives of clinicians, patient, carers in ways that help mutual understanding; (iii) recognising and identifying the ways in which illness changes the experience of one's body, identity, relationships, interaction with the environment, habits, routine, meanings, values and norms. Such a toolkit acknowledges the importance of both the biological and social but also, and most importantly perhaps, the interweaving of both as factors jointly underpinning an older person's movement along the continuum of robust, pre-frail and frail. In so doing it opens up the chance to restore healthy ageing by sensitive means in appropriate domains in (iii).

CGA is a highly sensitive vehicle for delivering such interventions and the introduction of a CGA toolkit into primary care is thus a promising development. However, there is still a danger that frailty is decoupled from CGA and thus it will be important to ensure that these principles are not just applied in older people with frailty syndromes of any stage, or with severe frailty [17], but that they inform the understanding of health, illness and normality in all older patients, as well as the concept of, and practices around, frailty itself. A reconfiguring of the understanding of and approach to frailty to include a broader approach lies at the heart of a reconceptualisation of health and illness in old age, which in turn gives geriatric medicine, as it is deployed by all branches of medicine [39] a key role in an ageing world, not just in terms of intervening in frailty but in supporting health ageing in the wider population.

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**Conclusion**

Geriatric medicine as a specialty has the skills and expertise to bridge the gap between older people’s lived experience of both old age and frailty and the current clinical approach to frailty by placing commitment to the principles on which it was founded at the very heart of its approach. It can do this by reinstating the importance of the social alongside the medical, appreciating the two as both distinguishable elements and one that are always, like yin and yang, already intertwined. Together and relatedly this will involve a recognition of resources as well as deficits present in the state of being frail and of the continuum of health, illness and frailty. We suggest that concepts and methods from the social sciences and humanities will be particularly helpful in this project. Invigorated by such principles, such a medical approach has the powerful potential to influence cultural views towards ageing in a more positive way, reducing the dread towards the fourth age and the ‘othering’ of (frail) older people that is detrimental to the well-being not just of the older people themselves but of a society that fears, dreads and denies ageing. This is important if frailty as a construct is to realise its full potential to ameliorate the vulnerabilities of later life, without itself inducing undesirable effects, and thus to engage most productively and sensitively with the people whom it is dedicated to help.

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